



Physical Therapy
PATIENT INFORMATION

Last name _____ First _____ MI _____
 DOB _____ SS# _____ Email _____
 Street Address _____ City _____ Zip _____
 Phone _____ Work _____ Cell _____
 Emergency contact _____ Emergency Contact phone _____
 Employer Name _____ Address _____
 How did you learn about VitalEnergy? _____
 Name of Insured if other than Patient _____ DOB _____

DO NOT WRITE BELOW LINE

OFFICE USE ONLY

Referring
 Doctor _____ Phone# _____
 Clinic Name _____ Fax# _____
 Address _____
 Contact _____
 Diagnosis/Code _____
 Script Date _____
 Primary _____ Date _____ Effective _____
 Insurance _____ Verified _____ Date _____

In-Network

Deductible _____
 Renew: Cal.yr / Group yr _____
 Ded Met No/Yes _____
 Applies to OON Deduct: No/Yes/NA _____
 Copay/Coinsurance _____ %

Out-of-Network

Deductible _____
 Renew: Cal.yr / Group yr _____
 Ded Met No/Yes _____
 W/O No/ Full/ Partial _____
 Applies to In-net Deduct: No/ Yes/ NA _____
 Coinsurance _____ %
 Send OON notification NO/Yes

Visit Limit (#/\$) _____ OT Only / PT Only / OT & PT Combined Renew: Cal yr / Group yr
 Refer MD Script required No / Yes Will PT Eval/POC Suffice No / Yes / NA
 Authorization Required No / Yes Pre-cert Phone# _____
 Red Flag _____

Name _____ Benefits _____
 Secondary Insurance _____ Pay _____
 Name _____ Benefits _____
 Medicare Supplemental _____ Pay _____

Copay/Coinsurance \$ _____ Deductible to pay \$ _____ Visit Limit _____

Initials:	Contact name:	Date:	Time:
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TO VITAL ENERGY OCCUPATIONAL THERAPY & WELLNESS CENTER PATIENTS:

All of us at Vital Energy Occupational Therapy & Wellness Center wish to thank you for choosing our clinic for your therapy needs. In order to better serve our patients, and to keep our charges to a minimum, we would like to advise you of our clinic policies as follows:

YOUR INSURANCE:

We make every effort to review your insurance benefits with your insurance carrier and you to make you aware of your financial responsibility for your rehabilitation needs. However, some insurance plans are difficult for us to get a clear picture of your out of pocket costs. We have done our best to outline your individual plan. Ultimately, it is your responsibility to understand your individual coverage and pay for services rendered. Unless other arrangements have been made in advance either by you or your health coverage carrier payment is due at the time of service.

1) **CO-PAYMENTS & DEDUCTIBLES MUST BE PAID AT TIME OF SERVICE.** Our contracts with various insurance companies require that we collect deductibles and patient co-pays at the time of service. We are in violation of our contract if we fail to do so. We verify your remaining deductibles and coverage with your insurance company at your first visit. The contracts require that we base our deductible charges and collect estimated co-pays based upon this information until we receive an Explanation of Benefit (EOB) and first payment from your insurance company (usually 4-6 wks after date of service). After we receive the first EOB, we adjust your deductible according to the information shown there. Your insurance policy dictates what **we must collect** at each visit.

We accept credit cards, debit cards, cash or check. Parents of students coming alone for treatments may make arrangements to pay weekly. We will make every effort to provide you with an agreeable payment plan, if needed; but if your account is turned over to a collection agency, you are responsible for an **additional 30% collection fee**. Because of lack of privacy, we ask that you **do not call the clinic to discuss financial issues**.

2) CANCELLATION NOTICE: We require a minimum of 24 hrs. notice for cancellation or we reserve the right to charge \$40 for the missed appointment. If this is impossible, please be courteous and give us as much advance notice as possible to enable us to contact other patients who might need this time. Parents, please advise student patients of this policy and follow up to make sure that they keep appointments.

Thank you once again for your patronage and cooperation with our policies.

Date _____ Date _____
Patient or Responsible Party
Signature

Witness



Privacy Policy

Any questions or concerns about privacy issues are to be directed to the Office Manager, Suzy Shay, or the privacy officer, Hima Dalal.

The subjective portion of evaluations will be performed in private. If other individuals are in the office, privacy may always be requested by the patient at any time and a private situation will be arranged.

While in the gym area, Vital Energy staff will be as discrete as possible with health information.

The file cabinet or the office will be locked when Vital Energy staff are away to protect medical records.

Prudent and careful judgment should be used during telephone conversations when non-staff persons are in the clinic to protect health information of patients.

Medical information of patients will be protected. Medical information will be released by a patient's written consent and/or in response to a court order. If physical abuse is suspected, medical information may be released to appropriate individuals by the privacy officer only.

Any patient at any time can request and receive a copy of their medical records. It may take 72 hours and there may be a charge for this service.

I, _____, have read the above privacy policy of Vital Energy Therapy and agree to the policies therein.

Patient signature (or legal guardian)

Date: _____



Release of Medical Information

- I have had diagnostic tests or surgical procedures performed and grant my physician, _____, permission to release the following reports to Vital Energy Occupational Therapy & Wellness Center:

- I authorize Vital Energy Occupational Therapy & Wellness Center to release any medical information regarding this injury/condition to the following:
- My health insurance company
- Referring physician
- Work Comp carrier/employer if work comp injury
- _____
- _____

Assignment of Benefits

- I authorize Vital Energy Occupational Therapy & Wellness Center to file insurance on my behalf and accept assignment of my benefits to Vital Energy Occupational Therapy & Wellness Center.

Privacy Policy

- I have been made aware the privacy policy of Vital Energy Occupational Therapy & Wellness Center is posted and I may request a copy at any time.

Signature _____ **Date** _____

Relationship if other than patient _____



MODEL RELEASE/INTERNAL USE ONLY

By signing this Photo/Audio/Video Release Form, I hereby consent to have my photograph taken or be videotaped, filmed, or have my voice recorded by or on behalf of Vital Energy Occupational Therapy & Wellness Center for the general purposes of training and education, or for the promotion of Vital Energy personnel, facilities or activities or for information that is deemed newsworthy.

Specifically, I authorize Vital Energy Occupational Therapy & Wellness Center to publish the resulting images at will in brochures, newsletters, newspapers, and other printed matter or broadcast audio/video/film on television, radio, or for other uses.

SIGNATURE OF MODEL

PLEASE PRINT:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____

WITNESS

DATE



Hydrotherapy Screening

Are you capable of swimming?	Yes	No
Skin Allergies	Yes	No
Sensitivity to chemicals	Yes	No
Open wounds	Yes	No
Contagious skin conditions (i.e. impetigo)	Yes	No
Rashes	Yes	No
MRSA	Yes	No
Eczema	Yes	No
Psoriasis	Yes	No
Respiratory infections	Yes	
COPD	Yes	
Unstable angina	Yes	
Uncontrolled diabetes	Yes	
Hypoglycemia	Yes	
Active Seizures	Yes	
Incontinence	Yes	
Diarrhea	Yes	
Active joint inflammation	Yes	
Deep vein thrombosis	Yes	
Bladder infection	Yes	
Pace maker	Yes	

I am a participant, willingly, in aquatic therapy and understand that Vital Energy Occupational Therapy & Wellness Center is not responsible for any adverse effects or harm caused in the Hydroworx pool area. I will follow all safety rules per the policies and the therapist.

Patients Signature

Date: _____

Parent or Guardian if patient is a minor child

Date: _____



The purpose of this questionnaire is to help us understand your health status.
Please complete this form and your therapist will answer any questions during your exam.
This form is considered part of your medical record.

Patient Name _____ DOB _____

Today's Date _____

1) When was your last general health check up? _____

Have you ever been told that you have:

High Blood Pressure	Yes	No	
Heart Problems	Yes	No	
Lung Problems	Yes	No	
Kidney Problems	Yes	No	
Head Injury	Yes	No	
Stroke/Neurological Problems	Yes	No	
Liver Problems	Yes	No	
Thyroid Problems	Yes	No	
Blood Disorders	Yes	No	
Diabetes (High Blood Sugar)	Yes	No	
Hypoglycemia (Low Blood Sugar)	Yes	No	
Past fractures/dislocations	Yes	No	
Asthma	Yes	No	
Seizure	Yes	No	
Cancer	Yes	No	
Arthritis	Yes	No	
Shingles	Yes	No	
Ringing Ears	Yes	No	
Tuberculosis or Hepatitis	Yes	No	
Repeated Infections	Yes	No	
Depression	Yes	No	
Osteoporosis	Yes	No	
Circulation/Vascular Problems	Yes	No	
Ulcer/Stomach Problems	Yes	No	
2) For Men Only			
Prostate Disease	Yes	No	
3) For Women Only			
Pelvic Inflammatory Disease	Yes	No	
Endometriosis	Yes	No	
4) Have You Recently Had:			
Unexplained Weight Loss/Gain	Yes	No	
Loss of Appetite	Yes	No	

Unexplained Fever or Chills	Yes	No	
Unremitting Night Pain	Yes	No	
Joint Pain or Swelling	Yes	No	
Urinary or Bowel Problems	Yes	No	
Fatigue/Malaise/Tiredness	Yes	No	
Numbness or Tingling	Yes	No	
Weakness in Arms or Legs	Yes	No	
Recent Falls or Loss of Balance	Yes	No	
Coordination Problems	Yes	No	
Difficulty Walking	Yes	No	
Dizziness or Loss of Consciousness	Yes	No	
Chest Pain	Yes	No	
Heart Palpitations	Yes	No	
Shortness of Breath	Yes	No	
Difficulty Swallowing	Yes	No	
New Onset of Headaches	Yes	No	
Visual Problems	Yes	No	
Hearing Problems	Yes	No	
Hoarseness	Yes	No	
Cough	Yes	No	
5) Do You Smoke?	Yes	No	If yes, how many? Packs/day How long have you smoked?
6) List any hospitalizations/surgeries			
7) List any other medical problems			
8) Any allergies?			
9) List your current medications			
10) Have you had a bone density test	Yes	No	If yes, when?
11) Reviewed by:			

Treatment Authorization for Vital Energy Occupational Therapy & Wellness Center:

I acknowledge I have answered the above information to the best of my knowledge. I voluntarily consent and agree to actively participate in such services as assessments, treatments, personal care, and therapeutic exercise on land or in water, as prescribed by the staff of Vital Energy Occupational Therapy & Wellness Center and will not hold them responsible for any adverse effect, harm, or side effects.

Signature _____

Date _____